

Legal Name of Applicant Agency:	COLLIN COUNTY
Mailing Address: Street / PO Bo	x: 825 N. MCDONALD ST #130
	y: MCKINNEY, TX
Zij	o: <mark>75069</mark>
Davis Name	COLLINICOLINITY
Payee Name:	COLLIN COUNTY
Payee Mailing Address:	
	x: 825 N. MCDONALD ST #130
· · · · · · · · · · · · · · · · · · ·	y: MCKINNEY, TX
ΖΙ	o: <mark>75069</mark>
State of Texas Comptroller Vendor ID # (9	
digit + 3 digit mail code):	
<b>DUNS #</b> (9 digits required for subrecipient contractors):	74873449
Type of Entity (Choose one)	
Cit	
Count	
Other Political Subdivision	1:
Project Period	
	e: Upon execution
End Date	e: 7/31/2023
Counties Served	
County(ies) Served	d:
334y(133) 331.13	
	COLLIN COUNTY
Amount of Funding Allocated:	\$570.348.00

## **CONTACT PERSON INFORMATION**

COLLIN COUNTY

Legal Business Name:

This form provides information about a following information changes during		 n addition to those on the FACE PAGE. If any of the o the Contract Management Unit.
Health Director/CEO	Candy Blair	Mailing Address (street, city, county, state, & zip):
Phone: 972-548-5504	Ext:	Maining Address (street, oity, county, state, & zip).
Fax:		
E-mail: cblair@co.collin.tx.us		825 N. MCDONALD #130, MCKINNEY, TX 75069
B-13/FSR Rep:	JARRAD WINMAN	Mailing Address (street, city, county, state, & zip):
Phone: 972-548-4732	Ext:	
Fax:	LINTYLIC	2200 PLOOMPALE DD. #4402 MCKININEV TV. 75000
E-mail: <u>JWINMAN@CO.COL</u>	LIN. 1 X.US	2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069
PHEP (HAZARDS) Program Leader:	Taylor Burton	Mailing Address (street, city, county, state, & zip):
Phone: 972-548-4464	Ext:	
Fax: tburton@co.collin.tx.u	IS	825 N. MCDONALD #130, MCKINNEY, TX 75069
		525 TH MODEL WILL WILL THE TOTAL THE
SNS (CRI) Coordinator: Phone: 972-548-4473	Amy Davis	Mailing Address (street, city, county, state, & zip):
Phone: 972-548-4473 Fax:	Ext:	
E-mail: aldavis@co.collin.tx.u	JS SL	825 N. MCDONALD #130, MCKINNEY, TX 75069
Authorized Signatory for DocuSign	CHRIS HILL	Mailing Address (street sity county state & zin):
Authorized Signatory for <b>DocuSign</b> Phone: 972-548-4623	Ext:	Mailing Address (street, city, county, state, & zip):
Fax:		
E-mail: CHILL@CO.COLLIN.	TX.US	2300 BLOOMDALE RD. #4192, MCKINNEY, TX 75069
Additional Authorized Signatory for		
DocuSign only if applicable		
(FFATA, Certs, etc)		
Phone:	Ext:	
Fax: E-mail:		
L-IIIaii.		
DocuSign "CC" Person	JARRAD WINMAN	
Phone: 972-548-4732	Ext:	
Fax:  E-mail: JWINMAN@CO.COL	LINTXUS	
Emergency Contact Cell Phone: 469-500-5538	SAMUEL GRADER Ext:	Mailing Address (street, city, county, state, & zip):
Cell Phone: 469-500-5538 Fax:	EXI.	
E-mail: SGRADER@CO.COI	LLIN.TX.US	825 N. MCDONALD #130, MCKINNEY, TX 75069

# **BUDGET SUMMARY (REQUIRED)**

Legal Name of Respondent: COLLIN COUNTY

Budget Categories	Total Budget	DSHS Funds Requested	Direct Federal Funds	Other State Agency Funds*	Local Funding	Other Funds
	(1)	(2)	(3)	(4)	(5)	(6)
A. Personnel	\$325,469	\$325,469				
B. Fringe Benefits	\$137,511	\$137,511				
C. Travel	\$8,076	\$8,076				
D. Equipment	\$0	\$0				
E. Supplies	\$61,457	\$61,457				
F. Contractual	\$0	\$0				
G. Other	\$37,835	\$37,835				
H. Total Direct Costs	\$570,348	\$570,348				
<ol> <li>Indirect Costs</li> </ol>	\$0	\$0				
J. Total (Sum of H and I)	\$570,348	\$570,348				

Revised: 04/14/2014

## **PERSONNEL Budget Category Detail Form**

Legal Name of Respondent:	COLLIN COUNTY

PERSONNEL  Name + Functional Title	Vacant Y/N	Job Summary	FTEs	Certification or License (Enter NA if not required)	<u>Estimated</u> Monthly Salary/Wage	Number of Months	Salary/Wages Requested for Project
Epidemiologist	N	Performs disease & contact investigations, COVID-2019 surveillance and reporting	1.00	NA	\$5,601	15	\$84,015
Epidemiologist	N	Performs disease & contact investigations, COVID-2019 surveillance and reporting	1.00	NA	\$5,601	15	\$84,015
Epidemiologist		Performs disease & contact investigations, COVID-2019 surveillance and reporting	1.00	NA	\$5,593	23	\$128,639
Internship	Υ	Provides administrative support for Epidemiology	1.00	NA	\$1,600	18	\$28,800
							\$0
							\$0 \$0
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							\$0
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							\$0 \$0
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							\$0
				TOTAL FROM PERSON	INEL SUPPLEMEN	TAL SHEETS	\$0
					SalaryWag	e Total	\$325,469

FRINGE BENEFITS Itemize the elements of fringe benefits in the space below:

a. Fringe Benefits: FICA/Medicare (salary x 0.0765), Insurance Premiums (\$1,300 for medical/dental/RX and \$4.95 for term life per month), Long Term Disability (salary x 0.0024), Short Term Disability \$2.10/month, Long Term Care \$26.25 per month, Retirement (salary x 0.08), Supplemental Death Benefit (salary x 0.0025), Unemployment insurance (salary x 0.001). Per life insurance HR, the calculation should be employee salary divided by 1000 and then multiplied by 0.05 (this is for one month). Long-Term Disability \$0.0024. Short-Term Disability \$2.10 per month. Long-Term Care \$30.08 per

Total Number of FTEs:	4.00	Fringe Benefit Rate %	42.25%
		Fringe Benefits Total	\$137,511

#### TRAVEL Budget Category Detail Form

Legal Name of Respondent:		COUNTY	Budget Category De	tali Fo	rm		
	OOLLII	COUNT					
ference / Workshop Travel Costs							
Description of Conference/Workshop			Justification	Location City/State	Number of: Days & Employees	Travel (	osts
				City/State	Days & Employees		
						Mileage	
						Airfare	
						Meals	
						Lodging	
						Other Costs	
						Total	\$0
						Mileage	
						Airfare	
						Meals	
						Lodging	
						Other Costs	
						Total	\$0
						Mileage Airfare	\$0
							\$0
						Meals	\$0 \$0
						Lodging Other Costs	\$0
						Other Costs Total	\$0
	1				1	Mileage	\$0
						Airfare	\$0
						Meals	\$0
						Lodging	\$0
						Other Costs	\$0
						Total	\$0
					l .	Total	***
	TOTA	L FROM TRAV	/EL SUPPLEMENTAL CONFERENCE			_	\$0
	_		Total fo	or Confere	nce / Workshop	Travel	\$0
r / Local Travel Costs		Number of		Mileago	ı		
Justification		Number of Miles	Mileana Daimhumannant Data	Mileage Cost	Other Costs	Tota	
Justilication			Mileage Reimbursement Rate	(a)	(b)	(a) +	
meetings, seminars, exercises, training	20				1.7		
ng all day travel within DFW metroples d by all staff performing COVID-19 duti	x will be	14421	\$0.560	\$8,076			\$8,076
				\$0			\$0
				\$0			\$0
				\$0			\$0
				\$0			\$0
				\$0			\$0
				\$0			\$0
	TOTAL FF	ROM TRAVEL	SUPPLEMENTAL OTHER/LOCAL TR	AVEL COSTS	BUDGET SHEETS		\$0
				Total	for Other / Loc	al Travel	\$8,076
Other / Local Travel Costs:	. co 070	٠	nference / Workshop Travel Costs:	\$0	Total Tra	val Casts:	40.070
	\$8,076	COI	ilerence / Workshop Haver Costs.	ψU	10141114	vei Cosis.	\$8,076

# **EQUIPMENT AND CONTROLLED ASSETS Budget Category**

## **Detail Form**

Logal Name of Despendents	COLLIN COUNTY
Legal Name of Respondent:	COLLIN COUNTY
·	

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order/quote.

Description of Item		Number of Units	Cost Per Unit	Total Cost
None				\$0
				\$0
				\$0
				\$0
				\$0 \$0 \$0 \$0 \$0 \$0 \$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0
				\$0 \$0 \$0 \$0 \$0
				\$0
				\$0
				\$0
	TOTAL FROM EQUIPMENT SUPP	LEMENTAL B	UDGET SHEETS	\$0

Total Amount Requested for Equipment:	\$0

## **SUPPLIES Budget Category Detail Form**

### Legal Name of Respondent:

**COLLIN COUNTY** 

Itemize and describe each supply item and provide an estimated quantity and cost (i.e. #of boxes & cost/box) if applicable. Provide a justification for each supply item. Costs may be categorized by each general type (e.g., office, computer, medical, educational, etc.)

Description of Item Provide estimated quantity and cost	Purpose & Justification	Total Cost
Computer-Tablets x 2 including docking station, key board, stylus, mouse, and three monitors; \$2677 each; For (1) Epidemiologist, Internship	investigations, creating documentation, analyzing data, and other public health activities	\$5,354
Desk Phones x 2; \$308.00 ea; For (1) Epidemiologist, Internship	Desk phones to be used by health department staff to communicate with stakeholders, providers and others regarding disease investigations	\$616
Cell Phone x1 includes standard mobile phone, case, and car charger; \$247.99 ea; For (1) Epidemiologist	Cell phones to be used by health department staff to communicate with patients, healthcare providers and others regarding disease investigations	\$248
MiFi Device X 4; MiFi Device cost \$50 each, For (3) Epidemiologist, Internship	MiFi devices to be used by staff with their cell phone and/or tablet to access the county network, internet, and other software to conduct disease investigations while working remotely	\$200
Scanner - Top Feed x 2; county standard desktop scanner; \$1088 ea; For (1) Epidemiologist, Internship	Scanners to be used by staff to produce electronic files for retention of disease investigation reports and related documents	\$2,176
Office Supplies	Clipboards, paper, writing utensils, labels, folders, binders, etcto produce reports, documentation, and support grant functions. (Individual supply items will not exceed \$499.00)	
Printer-Color-Medium with additional paper tray x 1; \$928 each printer, \$291 each tray; For (1) Epidemiologist	Printers to be used by staff to produce grant related documents	\$3,000 \$1,369
4x Workstation Desk Package for staff; \$3758 each; for (3) Epidemiologists, Internship	Cost for necessary furniture required due to new positions resulting from expanded workforce.	\$15,032
Supplies for Testing and Transport of Specimens	Biohazard bags and shipping boxes, swabs, COVID-19 testing kits, and other supplies to support health department for providing disease testing to patients and/or public.	\$33,462
	TOTAL FROM SUPPLIES SUPPLEMENTAL BUDGET SHEETS	\$0

**Total Amount Requested for Supplies:** 

\$61,457

## **CONTRACTUAL Budget Category Detail Form**

Legal Name of Respondent:	<u>COLLIN COUNTY</u>

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates \$100,000 or more of the scope of the project in the respondent's funding request, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Payments	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL COST
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
					·	\$0
						\$0
	TOTAL FROM CONTRACTUAL SUPPLEMENTAL BUDGET SHEETS \$0					

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Total Amount Requested for CONTRACTUAL:	\$

## **OTHER COSTS Budget Category Detail Form**

## Legal Name of Respondent: COLLIN COUNTY

Description of Item Include quantity and cost/quantity	Purpose & Justification	Total Cost
Adobe DC software licenses x4; cost \$360 ea; (3) Epidemiologist, Internship	Computer software to be used by health department staff to edit, combine, and sign electronic .pdf documents used in stakeholder outreach tasks.	\$1,440
Software-EA licenses X 4 including Microsoft Office Suite; \$762 ea.; (3) Epidemiologist, Internship	Computer software to be used by health department staff to communicate by email, produce disease reports, enter and track disease surveillance data	\$3,048
Software for building vaccine data collection system interfaces, data processing, and data visualizations - License type and quantity will vary	Software examples may include licenses and maintenance fees for Laserfiche, Jotform, DocuSign, Tableau, ArcGIS, SQL, or other systems.	\$19,639
Cell Phone Service Plan x 3, for X 2 years; annual cost of voice and data plan \$576 ea; For (3) Epidemiologist	Cell phone voice and data service plan to be used by health department staff using their cell phones to communicate with stakeholders, providers, and others regarding disease investigations	\$3,456
Printing and Communication Materials	Printing for additional grant related activities, events and public education or other outreach brochures, flyers, postcards, coloring books, posters and other materials to educate the public; printing of employee business cards, as needed.	
		\$6,500
Postage	Postage for outreach materials, mailings, and communications with stakeholders.	\$200
MiFi Device Service Plan X 4 for 2 years for personnel; annual cost of MiFi Service \$444 ea; For (3)	MiFi devices to be used by staff with their cell phone and/or tablet to access the county network, internet, and other software to conduct disease investigations while working remotely	
Epidemiologist, Internship		\$3,552
	TOTAL FROM OTHER SUPPLEMENTAL BUDGET SHEETS	\$0

**Total Amount Requested for Other:** 

\$37,835

#### **Indirect Costs**

	Legal Name of Respondent:	COLLIN COUN	ITY_
	Total amount of indirect costs allocable to the project:	Amount:	
Indirect cos	sts are based on (mark the statement that is applicable):		
	The respondent's most recent indirect cost rate approved by a federal cognizant agency or state single audit coordinating agency. Expired rate agreements are not acceptable. Attach a copy of the rate agreement to this form (Form I - 7 Indirect)	RATE: BASE:	
	Applies only to governmental entities . The respondent's current central service cost rate or indirect cost rate. Attach a copy of Certification of Cost Allocation Plan or Certification of Indirect Costs.  Note: Governmental units with only a Central Service Cost Rate must also include the indirect cost of the governmental units department (i.e. Health Department). In this case indirect costs will be comprised of central service costs (determined by applying the rate) and the indirect costs of the governmental department. The allocation of indirect costs must be addressed in Part V - Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS.	RATE: TYPE: BASE:	
	A cost allocation plan. A cost allocation plan as specified in the DSHS Contractor's Financial Procedures Manual (CFPM), Appendix A must be submitted to DSHS within 60 days of the contract start date.		
	GO TO PAGE	2 (below)	
	Page 2, FORM I -	7 Indirect	Costs
If using a	n <u>central service</u> or <u>indirect cost rate</u> , identify the types of costs t	hat are included	(being allocated) in the rate:

Organizations that do not use an indirect cost rate and governmental entities with only a central service rate must identify the types of costs that will be allocated as indirect costs and the methodology used to allocate these costs in the space provided below. The costs/methodology must also be disclosed in Part V-Indirect Cost Allocation of the Cost Allocation Plan that is submitted to DSHS. Identify the types of costs that are being allocated as indirect costs, the allocation methodology, and the allocation base:

## SUPPLEMENTAL INSTRUCTIONS

The budget templates include a SUPPLEMENTAL page (one per budget category) that are intended to supplement cost reimbursement budgets when there are too many items to fit on the primary budget template.

The amounts on each supplemental template will automatically populate from the templates and will be inserted on the last line of the primary budget template.

The SUPPLEMENTAL budget templates are:

Personnel Supplemental
Travel Supplemental
Equipment & Controlled Assets Supplemental
Supplies Supplemental
Contractual Supplemental
Other Costs Supplemental

## **PERSONNEL Budget Category Detail Form (Supplemental)**

Legal Name of Respondent: COLLIN COUNTY

Name + Functional Title							1		
Name + Functional Title	PERSONNEL	<b>.</b> .	ı., .			Certification or	Estimated	Number	Salary/Wages
Computer to used by health department staff for vaccine support operations.			Joh Summary	FTFe		Monthly Salan/Wage		Requested for Project	
department staff for vaccine support operations.	Name + Functional Title	1714		11123	not required)	Odiai y/Wage	WOILLIS	Troject	
Operations.			department staff for vaccine support					\$0	
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Legal Name of Respondent:	COLLI	COUNTY					
onference / Workshop Travel Costs							
Description of				Location	Number of:		
Conference/Workshop			Justification	(City, State)	Days & Employees	Travel Costs	
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						Meals	
						Lodging	
						Other Costs	
						Total	\$
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Justification		Number of Miles	Mileage Reimbursement Rate	Mileage Cost	Other Costs	Total	
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Other / Local Travel Costs	: \$0	Cont	ference / Workshop Travel Costs:	\$0 \$0	or Other / Loca	_	\$1

Revised: 3/25/2014	

# **EQUIPMENT AND CONTROLLED ASSETS Budget Category**

# **Detail Form (Supplemental)**

Legal Name of Respondent:	COLLIN COUNTY

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached example for equipment definition and detailed instructions to complete this form.

Description of Item	Purpose & Justification	Number of Units	Cost Per Unit	Total
				\$0
				\$0 \$0 \$0 \$0 \$0 \$0
				\$0
				\$0
				\$0
				\$0
				\$0 \$0
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				\$0
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			_	\$0
				\$0 \$0 \$0 \$0

Total Amount Requested for Equipment:	\$

# **SUPPLIES Budget Category Detail Form (Supplemental)**

Legal Name of Respondent:	COLLIN COUNTY	
Itemize and describe each supply item and provide an estimated qual be categorized by each general type (i.e., office, computer, medical, clie Description of Item	antity and cost (i.e. # of boxes & cost/box) if applicable. Provide a justification for each ient incentives, educational, etc.)	supply item. Costs may
		<u> </u>
[If applicable, provide estimated quantity and cost (i.e. # of boxes & cost/box)]	Purpose & Justification	Total Cost
		\$0
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	Total Amount Requested for Supplies:	\$0

# **CONTRACTUAL Budget Category Detail Form (Supplemental)**

Legal Name of Respondent:	<u>COLLIN COUNTY</u>

List contracts for services related to the scope of work that is to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that de

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	Justification	METHOD OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	# of Months, Hours, Units, etc.	RATE OF PAYMENT (i.e., hourly, daily, weekly, monthly, quarterly, cost reimb., unit rate, lump sum)	TOTAL
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0
						\$0

· · · · · · · · · · · · · · · · · · ·	
Total Amount Requested for CONTRACTUAL:	\$0

### OTHER COSTS Budget Category Detail Form (Supplemental)

Description of Item [If applicable, include quantity and cost/quantity (i.e. # of units & cost/unit)]	Purpose & Justification	Total Cost

Total Amount Requested for Other:	\$0